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Op-Ed

Hospital Community Benefit Spending: Leaning In on the Social Determinants of Health

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For as long as the Internal Revenue Code has existed, federal tax policy has exempted corporate entities organized and operated for charitable purposes, as long as they meet applicable federal requirements. The Code does not identify the promotion of health as an explicit charitable purpose, but since 1956 the IRS has recognized that hospitals can qualify as tax-exempt charities. The 1956 standards identified the provision of charity care as the *sine qua non* of tax-exempt status. But in 1969 the Nixon administration revised the standard, eliminating charity care as a basic requirement and substituting in its place a nebulous "community benefit" standard that gave hospitals broad latitude to define activities that would benefit their communities. These activities ranged from financial assistance to uninsured and underinsured patients to participation in government insurance programs, research, health professions education and training, and other "community health improvement" activities identified by a hospital. Legal services advocates for the poor unsuccessfully sought to halt this basic shift in federal policy; over many decades, the IRS offered no further elaboration on its revised standard and engaged in virtually zero enforcement activities. With some notable exceptions, state laws, which typically parallel federal tax law, remained unenforced.[1]

Several important developments have led to renewed attention on tax-exempt hospitals' community benefit spending practices. The first development has been an intensifying focus on the social determinants of health, which contribute significantly to elevated health care spending because of the impact of poor health on the volume and intensity of care needed to address avoidable health problems.

A second major development has been the fundamental shift across public and private payers alike—encapsulated by Medicare payment

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reform policies under the Affordable Care Act (ACA)—that places special emphasis on reducing the rate of avoidable readmissions following the discharge of unstable patients with serious and chronic health conditions into community environments with deficient community-based health and health care supports. With this shift in payment policy has come the potential for greater convergence of public health and hospital business interests.

A third development has been a fundamental policy shift resulting from two related reforms that significantly alter federal law governing the community benefit activities of tax-exempt hospitals. In 2009, prodded by congressional oversight as well as widespread reports of excessive charges imposed on uninsured patients and unreasonable collection practices, the IRS issued a major new policy aimed at clarifying what constitutes acceptable hospital community benefit spending practices. This new policy is embedded in Schedule H,[2] which all hospitals claiming tax-exempt status must complete as part of their annual Form 990 tax filings. Schedule H defines with greater precision the range of hospital expenditures that the IRS considers as falling within the definition of community benefit. Chief among these expenditures are financial assistance to persons unable to pay and participation in Medicaid and other means-tested entitlement programs. Schedule H also describes other forms of community benefit spending, including research, health professions education, and, of special interest, community health improvement activities focused on the provision of care and services for which no payment is expected. Under this reformulated IRS policy, Medicare participation is excluded as a community benefit, as is bad debt write-off, because they are not considered "charitable." IRS policy also excludes "community-building" activities aimed at promoting community-wide interventions such as affordable housing and environmental improvements that address the "upstream" social conditions of health. But in the case of "community building," the IRS permits hospitals to claim such investments as community health improvement spending (and thus, as community benefits) as long as they submit additional justification. However, the latest IRS figures on community benefit spending for the 2011 tax year, submitted in a nonpublicized report to Congress in 2015, suggest that community health improvement spending remains negligible in relation to other activities.[3]

The 2009 revision of what constitutes a community benefit was followed by a series of amendments to the Internal Revenue Code's

tax-exemption provisions, enacted as part of the ACA. These amendments,[4] which once again make financial assistance a fundamental tenet of community benefit spending, require that all tax-exempt hospitals maintain such policies as well as procedures to ensure that assistance is offered at the time care is needed rather than withheld until a debt is uncollectable. The amendments also bar excessive charges and unreasonable debt collection practices.

Of special importance to public health, the ACA amendments further specify that tax-exempt hospitals undertake triennial community health needs assessments with public health and community input. As part of the needs assessment process, hospitals also must link their assessments to implementation strategies that are updated annually and that describe how hospitals will prioritize their responses to the results of their assessments. Although the ACA does not expressly link hospital community benefit spending to hospital implementation strategies—it is too soon to tell whether hospital community benefit spending patterns will begin to change in response to these reforms—one might hope that assessing needs and developing implementation blueprints will yield closer ties between community benefit and community health. Indeed, hospitals themselves have sought to broaden the community benefit spending concept to clearly encompass upstream community-building activities.

The public interest in promoting more attention to improving community health is great, not only because of the public health value of a community-wide health focus but also because of the size of the public investment in tax-exempt hospitals. One estimate suggests[5] that in 2011 the nationwide value of federal hospital tax-exempt policy reached $24.6 billion, when all forms of tax relief were factored into the equation. Moreover, as the ACA's public and private insurance reforms have produced measurable reductions in the size of hospitals' uncompensated care burdens, attention has grown regarding how hospitals will invest these gains in their communities. Clearly the need for financial assistance remains a pressing one, particularly in the 19 states that, as of January 2016, still had not extended Medicaid to all poor residents made eligible for coverage under the ACA. The need for continuing hospital patient financial support is further underscored by high cost-sharing burdens that, according to the Kaiser Family Foundation, have left 1 in 5 insured, working-age Americans struggling to pay their medical bills.

At the same time, even a modest increase in hospital spending on community health improvement could lead to a major growth in

public health investments. The IRS report on hospital community benefit spending in the 2011 tax year concludes that hospitals devoted less than 5% of their $62.5 billion in total community benefit spending to community health improvement—nearly $2.7 billion out of $62.5 billion. If hospitals were to respond to these policy shifts by using even a portion of their additional revenues to lean in to public health, the impact could be significant.

References

1. Rosenbaum S, Frankford DM, Law SA, Rosenblatt RE. *Law and the American Health Care System*. 2nd ed. St. Paul, MN: Foundation Press; 2012.
2. Internal Revenue Service. Schedule H (Form 990). https://www.irs.gov/pub/irs-pdf/f990sh.pdf. Accessed February 5, 2016.
3. Internal Revenue Service. *Report to Congress on Private Tax-Exempt Hospitals and Government-Owned Hospitals*; January 2015.
4. 26 U.S.C. § 501(r).
5. Rosenbaum S, Kindig DA, Bao J, Byrnes MK, O'Laughlin C. The value of the nonprofit hospital tax exemption was $24.6 billion in 2011. *Health Aff*. 2015;34(7):1225-1233.

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